



# **Beck Hopelessness Scale**

# **MANUAL**

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# Introduction

## Background and Development

The *Beck Hopelessness Scale* (BHS; Beck, Weissman, Lester, & Trexler, 1974) is a 20-item scale for measuring the extent of negative attitudes about the future (pessimism) as perceived by adolescents and adults. The BHS was originally developed by Aaron T. Beck and his associates at the Center for Cognitive Therapy (CCT), University of Pennsylvania Medical School, Department of Psychiatry, to measure pessimism in psychiatric patients considered to be sui-cidal risks, but it has been used subsequently with adolescent and adult normal populations (Greene, 1981; Johnson & McCutcheon, 1981).

Hopelessness is a psychological construct that has been observed to underlie a variety of mental health disorders. After reviewing the literature on the hope-lessness construct, Stotland (1969) concluded that although many clinicians believed that hopelessness was too diffuse to be measured systematically, there was sufficient consensus to construct an instrument to evaluate negative attitudes concerning oneself and one's future. Drawing upon nine items from a test of attitudes about the future (Heimberg, 1961), Beck and his associates added 11 more items from a pool of pessimistic statements about the future which were collected from psychiatric patients who had described hopeless cognitions. The statements were selected to reflect a broad spectrum of negative attitudes about the future which were frequently mentioned by the patients.

The 20 statements were then administered to a random sample of depressed and nondepressed patients. The patients had been told about the purpose of the test, and were asked to evaluate the relevance and clarity of each statement. The statements were then reviewed by several clinicians for face validity and comprehensibility before being pilot tested as a scale called the *Generalized Expectancy Scale* (GES; Minkoff, Bergman, Beck, & Beck, 1973). For several years the GES was employed to measure hopelessness in suicide attempters and patients describing suicidal ideation. In 1974 the wording of some of the statements was changed slightly, and the present form of the BHS (Beck et al., 1974) was established.

The BHS adheres closely to Stotland's (1969) conception of hopelessness as a system of cognitive schemas in which the common denominator is negative expectancy about the short- and long-term future. Hopeless individuals believe: (1) that nothing will turn out right for them, (2) that they will never succeed at what they attempt to do, (3) that their important goals can never be obtained, and (4) that their worst problems will never be solved. This definition of hopelessness corresponds to the third component of the negative triad in

**Beck's** (1967) cognitive model of depression, consisting of: (1) a negative **view** of the self, (2) a negative view of present functioning, and (3) a negative view of the future.

### **Description and Content of the Scale**

The BHS consists of 20 true-false statements that assess the extent of negative expectancies about the immediate and long-range future. Each of the 20 state-ments is scored 1 or 0. Of the 20 true-false statements, 9 are keyed FALSE, and 11 are keyed TRUE to indicate endorsement of pessimism about the future. The item scores are summed to yield a total score that can range from 0 to 20 with higher scores indicating greater hopelessness. The 20 statements of the BHS and the corresponding responses which indicate hopeless cognitions are:

Statement	Response Key For Hopelessness
1. I look forward to the future with hope and enthusiasm.	F
2. I might as well give up because there is nothing I can do about making things better for myself.	T
3. When things are going badly, I am helped by knowing that they cannot stay that way forever.	F
4. I can't imagine what my life would be like in ten years.	T
5. I have enough time to accomplish the things I want to do.	F
6. In the future, I expect to succeed in what concerns me most.	F
7. My future seems dark to me.	T
8. I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.	F
9. I just can't get the breaks, and there's no reason I will in the future.	T
10. My past experiences have prepared me well for the future.	F
11. All I can see ahead of me is unpleasantness rather than pleasantness.	T
12. I don't expect to get what I really want.	T
13. When I look ahead to the future, I expect that I will be happier than I am now.	F

- |   |   |
|---|---|
| 14. Things just don't work out the way I want them to.                                      | T |
| 15. I have great faith in the future.   | F |
| 16. I never get what I want, so it's foolish to want anything.                              | T |
| 17. It's very unlikely that I will get any real satisfaction in the future.                 | T |
| 18. The future seems vague and uncertain to me.   | T |
| 19. I can look forward to more good times than bad times.                                   | F |
| 20. There's no use in really trying to get anything I want because I probably won't get it. | T |

### **Appropriate Uses**

The BHS measures the extent of negative attitudes about the future. It has a particular utility as an indirect indicator of suicidal risk in depressed examinees or individuals who have made suicide attempts. Although the BHS was not developed as a tool for detecting hopelessness in adolescent and adult normal populations, it has been used for such purposes (Durham, 1982; Fogg & Gayton, 1976; Greene, 1981). The instrument should, therefore, be used cautiously for screening purposes. The BHS has been employed with adolescents as young as 13 years of age (Johnson & McCutcheon, 1981; Topol & Reznikoff, 1982); however, until more information about the BHS' psychometric characteristics for an adolescent population has been collected, the instrument is recommended as most appropriate for adults over the age of 17.

### **User Qualifications**

The BHS may be administered and scored by paraprofessionals, but it should be used and interpreted only by professionals with appropriate clinical training and experience according to the guidelines established by the American Psychological Association's (1985) *Standards for Educational and Psychological Testing*. Since depression and suicidal risk may be associated with hopelessness in psychiatric patients, it is important that the clinician reviewing the BHS data be able to respond to the patient's hopelessness by having available a full range of appropriate psychotherapeutic interventions.

# Administration and Scoring

## Testing Conditions

The testing environment in which the BHS is administered must provide sufficient illumination for reading and be quiet enough to allow the patient to concentrate. Obviously, the test administrator must determine beforehand whether or not a patient can comprehend the BHS' item content.

## Administration Time

The BHS requires between 5 and 10 minutes to complete when self-administered. Oral administration generally takes 10 minutes, and some extremely obsessive examinees may require 15 minutes.

## Directions for Administration

The BHS is administered easily using the questionnaire available from the publisher. The Scale may be self-administered or administered orally by the examiner if the examinee needs assistance in completing the questionnaire.

## Self-Administration

Give the examinee the BHS questionnaire and read aloud the following instructions which appear at the top of the questionnaire: **This questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement describes your attitude for the *past week including today*, darken the circle with a 'T' indicating TRUE in the column next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' indicating FALSE in the column next to the statement. *Please be sure to read each statement carefully.***

## Oral Administration

The BHS also may be administered orally. In such cases the following instructions to the examinee are suggested: **This is a questionnaire. On the questionnaire there are statements. I will read each statement one by one. After I read the statement, I want you to tell me if it is TRUE or FALSE for you. Answer the statements in terms of how you have felt during the *past week, including today*. That includes right now. After giving these instructions, give the examinee a BHS questionnaire and say: Here is a copy for you so that you can follow along as I read.**



Read the first statement and say: **Now, is this statement TRUE or FALSE for you?** Then darken the appropriate circle next to the statement. If the examinee understands the instructions after a few sentences, you may then stop asking whether the statement is TRUE or FALSE for them.

Sometimes an examinee will take the initiative, read statements ahead of the tester, and start giving TRUE and FALSE answers. If the examinee is alert and knowledgeable, let him or her proceed in this manner. If necessary, use tact to encourage the examinee to reflect sufficiently before making a choice. Carefully inspect all of the TRUE and FALSE answers at the end of the testing to insure that no items have been overlooked or left blank. Ask the examinee to answer any omitted items. If an examinee is unsure about whether or not the statement is TRUE or FALSE, instruct the examinee to decide on the basis of whether or not the statement does or does not *mostly* describe him or her.

## **Response Sets**

Although the BHS has been roughly balanced between 11 positively and 9 negatively keyed statements with respect to hopelessness, the examiner must be extremely careful that the examinee does not use one type of response (either True or False) for all answers. If an examinee is not sufficiently reflecting upon whether or not a statement is true or false, tell the examinee that people seldom are alike with respect to every response and perhaps he or she might wish to reconsider some of the answers.

## **Scoring Guidelines**

The BHS is scored by summing the keyed responses of hopelessness for each of the 20 items. Scoring is facilitated by use of the BHS scoring key. To use the key, place it over the questionnaire and line up the logos, BHS. Responses indicating hopelessness will appear within the circles on the scoring key and receive a score of -1. Responses not appearing in circles indicate non-hopelessness and receive a score of 0. Add the total number of hopelessness responses and write this sum on the line provided at the bottom of the questionnaire. The maximum score is 20. Although cut-off scores should be based upon the clinical decisions for which an instrument is being employed, the CCT distributes general guidelines for interpretation in which 0 to 3 is within the normal range or asymptomatic, 4 to 8 is mild, 9 to 14 is moderate, and greater than 14 is severe.

The decision to employ different cut-off scores must take into consideration the sample and purposes for which the BHS is being employed. If the purpose is to

detect the maximum number of persons with negative attitudes about the future, the cut-off scores should be lowered to minimize false negatives (although the number of false positives will increase). This method would be useful in screening for possible cases of hopelessness. To reduce the number of false positives, the cut-off scores should be raised. This method is used for research purposes in which one wishes to obtain as pure a sample of hopeless persons as possible.

## **Interpretation of Scores**

Since the BHS score yields only an estimate of the overall severity of a person's negative attitudes about the future, it is clinically important to pay attention to other aspects of psychological functioning displayed by a patient, particularly the levels of depression and suicidal ideation. Beck, Steer, Kovacs, and Garri-son (1985) have reported that BHS scores of 9 or more were predictive of eventual suicide in depressed suicide ideators followed for 5 to 10 years after discharge from a hospital. In addition, hopelessness has repeatedly been found to be a better predictor of suicidal intention than depression per se (Beck, 1986). Therefore, patients describing moderate to severe levels of hopelessness should be closely scrutinized for suicide potential. Case vignettes are presented on pages 22-25 which illustrate the clinical utility of the *Beck Hopelessness Scale*.

## Psychometric Characteristics

Although studies have addressed the psychometric characteristics of the BHS across diverse samples of both psychiatrically diagnosed and normal populations, much of the data has been based on samples not diagnosed according to the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. (DSM-III) (American Psychiatric Association, 1980). Therefore, this Manual describes not only published studies, but it also provides additional data on seven normative samples used by the CCT in studying the BHS. Three of these samples were diagnosed according to DSM-III criteria using the Structured Clinical Interview for DSM-III (Spitzer & Williams, 1983).

Most studies of the BHS have been directed at suicidal behaviors, and some have been derived from a long-term prospective study of suicidal behavior which was begun by Beck and his associates at CCT in 1970 and completed in 1982 (Beck et al., 1985). Several of the studies describing the psychometric characteristics of the BHS drew upon consecutive cohorts of patients at suicidal risk who were admitted to the longitudinal study. The psychometric characteristics of the BHS for the final sample of 499 suicide attempters and 207 suicide ideators who were eventually included in the study are provided.

The psychometric characteristics of the BHS for 211 heroin addicts (Steer, Beck, & Shaw, 1985) and 105 alcoholics (Beck, Steer, & McElroy, 1982) drawn from a large community mental health center also are provided. In addition to these samples, 134 patients with recurrent-episode Major Depression Disorders, 72 patients with single-episode Major Depression Disorders, and 177 patients with Dysthymic Disorders were included.

## Characteristics of Sample Groups

**Suicide Ideators:** This group consisted of 96 (46.4%) males and 111 (53.6%) females. The racial composition was 62.3% ( $N = 129$ ) White and 37.7% ( $N = 78$ ) Black. The mean age was 33.92 ( $SD = 12.12$ ) years, and the mean educational attainment was 11.09 ( $SD = 2.48$ ) years. The marital status was 39.1% ( $N = 81$ ) single, 28.0% ( $N = 58$ ) married or cohabitating, and 32.9% ( $N = 68$ ) widowed, separated, or divorced. Alcohol abuse was described by 79 (38.2%), whereas 24 (11.6%) described themselves as drug abusers. Previous suicide attempts were described by 60 (29.0%) individuals, and 22 (10.6%) reported that at least one immediate family member had committed suicide. The DSM-II diagnoses were mixed, with the modal one being neurotic depression ( $N = 76$ , 36.7%).

**Table 1. Means, Standard Deviations, and Corrected Item Total Correlations by Sample Group**

Item Number	Suicide Ideators ( <i>N</i> = 165)			Suicide Attempters ( <i>N</i> = 437)		
	<i>M</i>	<i>SD</i>	<i>r<sub>tot</sub></i>	<i>M</i>	<i>SD</i>	<i>r<sub>tot</sub></i>
1	.42	.50	.62	.36	.48	.66
2	.25	.43	.67	.27	.45	.62
3	.31	.46	.49	.26	.44	.40
4	.82	.39	.24	.78	.41	.32
5	.35	.48	.43	.35	.48	.44
6	.28	.45	.63	.27	.44	.57
7	.63	.48	.66	.57	.50	.67
8	.61	.49	.51	.61	.49	.50
9	.41	.49	.52	.43	.50	.62
10	.41	.49	.38	.40	.49	.42
11	.45	.50	.72	.43	.50	.75
12	.59	.49	.64	.57	.50	.66
13	.33	.47	.73	.31	.46	.65
14	.69	.46	.61	.67	.47	.58
15	.50	.50	.70	.44	.50	.68
16	.37	.48	.55	.32	.47	.63
17	.38	.49	.67	.36	.48	.73
18	.70	.46	.59	.65	.48	.57
19	.38	.49	.75	.40	.49	.69
20	.40	.49	.65	.39	.49	.68
Total	9.28	6.08		8.86	6.11	
KR-20		.92			.93	

**Suicide Attempters:** Of the 499 suicide attempters, there were 212 (42.5%) males and 287 (57.5%) females. The racial composition was 252 (50.5%) White, 239 (47.9%) Black, and 8 (1.6%) other. The mean age was 30.15 (*SD* = 10.72) years, and the mean educational attainment was 10.93 (*SD* = 2.44) years. With respect to marital status, 217 (43.5%) were never married, 115 (23.0%) were married or cohabitating, and 167 (33.5%) were widowed, separated, or di-vorced. Only 110 (22.0%) of the attempters were employed. A history of drug abuse was described by 107 (21.4%), and 161 (34.1%) of the 472 for whom complete alcohol histories were available described a history of alcohol abuse. Furthermore, 179 (35.9%) had reported a prior suicide attempt, and 58 (11.6%) claimed that at least one of their immediate family members had committed suicide. The DSM-II diagnoses were mixed, with the modal one being neurotic depression (*N* = 194, 38.9%).

**Table 1. (continued) Means, Standard Deviations, and Corrected Item Total Correlations by Sample Group**

Item Number	Alcoholics ( <i>N</i> = 105)			Heroin Addicts ( <i>N</i> = 211)		
	<i>M</i>	<i>SD</i>	<i>r</i> <sub>tot</sub>	<i>M</i>	<i>SD</i>	<i>r</i> <sub>tot</sub>
1	.11	.32	.59	.08	.27	.50
2	.10	.31	.54	.02	.15	.36
3	.12	.33	.18	.18	.39	.25
4	.75	.43	.35	.61	.49	.19
5	.18	.39	.44	.17	.38	.35
6	.11	.32	.60	.06	.23	.28
7	.26	.44	.66	.17	.38	.57
8	.38	.49	.41	.45	.50	.31
9	.22	.42	.53	.17	.37	.40
10	.24	.43	.52	.25	.43	.37
11	.18	.39	.68	.12	.33	.54
12	.32	.47	.65	.22	.42	.51
13	.10	.31	.69	.08	.27	.46
14	.50	.50	.51	.36	.48	.39
15	.18	.39	.63	.20	.40	.56
16	.15	.36	.51	.07	.25	.39
17	.16	.37	.66	.11	.32	.47
18	.42	.30	.65	.31	.46	.40
19	.16	.37	.62	.13	.33	.47
20	.19	.39	.69	.11	.32	.43
Total	4.86	4.83		3.89	3.53	
KR-20		.91			.82	

**Alcoholics:** The alcoholic sample consisted of 76 (72.4%) males and 29 (27.6%) females. The sample was 69.5% Black, and the mean age was 37.99 (*SD*= 9.97) years. With respect to marital status, the sample was 13.3% married, 33.4% never married, and 53.3% widowed, divorced, or separated. The mean educational attainment was 10.51 (*SD* = 2.04) years.

**Heroin Addicts:** The sample consisted of 157 (74.4%) males and 54 (25.6%) females. The racial composition was 33% White and 67% Black. The marital composition was 45.4% single, 28.5% married, and 26.1% separated, divorced, or widowed. The mean age was 27.65 (*SD* = 5.81) years; 86.7% were unemployed; and the mean educational attainment was 11.01 (*SD* = 1.63) years.

Tablet. (continued) Means, Standard Deviations, and Corrected Item Total Correlations by Sample Group

Item Number	Single-Episode Major Depression ( <i>N</i> = 72)			Recurrent-Episode Major Depression ( <i>N</i> = 134)		
	<i>M</i>	<i>SD</i>	<i>r</i> <sub>tot</sub>	<i>M</i>	<i>SD</i>	<i>r</i> <sub>tot</sub>
1	.64	.48	.59	.68	.47	.62
2	.22	.42	.64	.15	.36	.43
3	.40	.49	.50	.42	.50	.45
4	.83	.38	.32	.77	.42	.52
5	.54	.50	.50	.54	.50	.26
6	.47	.50	.65	.51	.50	.61
7	.56	.50	.62	.57	.50	.64
8	.71	.46	.49	.67	.47	.45
9	.36	.48	.71	.34	.48	.52
10	.64	.48	.37	.64	.48	.42
11	.42	.50	.69	.47	.50	.66
12	.64	.48	.69	.62	.49	.72
13	.32	.47	.56	.34	.48	.57
14	.71	.46	.63	.68	.47	.64
15	.64	.48	.66	.72	.45	.67
16	.15	.36	.56	.20	.40	.57
17	.33	.47	.70	.39	.49	.72
18	.76	.43	.59	.86	.35	.50
19	.47	.50	.69	.52	.50	.68
20	.28	.45	.63	.28	.45	.56
Total	10.10	5.98		10.37	5.70	
KR-20		.92			.92	

**Single-Episode Major Depression:** This sample consisted of 41 (56.9%) females and 31 (43.1%) males. The mean age was 35.88 (*SD* = 11.80) years. Of the 48 patients for whom employment histories were available, 18 (37.5%) reported full-time employment, 4 (8.3%) reported part-time employment, 18 (37.5%) were unemployed, and 8 (16.7%) were students. With respect to marital status, 32 (44.4%) were single, 28 (38.9%) were married, 2 (2.8%) were cohabitating, 4 (5.6%) were separated, 5 (6.9%) were divorced, and 1 (1.4%) was widowed. Fifteen (20.8%) of the patients were described with melancholia.

**Recurrent-Episode Major Depression:** Patients in this group included 78 (58.2%) females and 56 (41.8%) males. The mean age for the recurrent episode major depressive disorders was 39.07 (*SD* = 13.71) years. Of the 111 patients for whom employment histories were available, 61 (55.0%) reported full-time employment, 11 (9.9%) reported part-time employment, 25 (22.5%) were unemployed, and 14 (12.6%) were students. With respect to marital status, 51 (38.1%) were single, 61 (45.5%) were married, 2 (1.5%) were cohabitating, 5 (3.7%) were separated, 9 (6.7%) were divorced, and 6 (4.5%) were widowed. Melancholia was described for 35 (26.1%).

**Table 1. (continued) Means, Standard Deviations, and Corrected Item Total Correlations by Sample Group**

Item Number	Dysthymic Disorder ( <i>N</i> = 177)		
	<i>M</i>	<i>SD</i>	<i>r<sub>tot</sub></i>
1	.58	.50	.61
2	.08	.28	.25
3	.36	.48	.46
4	.76	.43	.31
5	.49	.50	.06
6	.41	.49	.45
7	.50	.50	.64
8	.63	.48	.32
9	.25	.44	.47
10	.55	.50	.64
11	.36	.48	.56
12	.58	.49	.63
13	.41	.49	.52
14	.62	.49	.54
15	.64	.48	.64
16	.12	.32	.45
17	.26	.44	.57
18	.76	.43	.49
19	.47	.50	.65
20	.19	.40	.44
Total	9.03	5.01	
KR-20		.87	

**Dysthymic Disorder:** This sample included 118 (66.7%) females and 59 (33.3%) males. Of the 90 patients for whom employment histories were available, full-time employment was reported by 22 (24.4%), part-time employment was reported by 8 (8.9%), 42 (46.7%) were unemployed, and 18 (20.0%) were students. With respect to marital status, 70 (39.5%) were single, 60 (33.9%) were married, 19 (10.7%) were separated, 25 (14.1%) were divorced, and 3 (1.7%) were widowed. The mean age for the dysthymic disorder sample was 36.90 (*SD* = 11.98) years.

## Reliability

### Internal Consistency

The means, standard deviations, and corrected item-total correlations ( $r_{\text{tot}}$ ) of the 20 BHS items for each of the seven normative samples are presented in Table 1. The Kuder-Richardson (KR-20) reliabilities for the suicide ideators, suicide attempters, alcoholics, heroin addicts, single-episode Major Depression Disorders, recurrent-episode-Major Depression Disorders, and Dysthymic Disorders were .92, .93, .91, .82, .92, .92, and .87, respectively. These estimates indicate that the BHS maintains high internal consistency across the seven clinical samples. Research reported by Durham (1982) indicates that reliability may be lower in college students ( $\text{KR-20} = .65$ ).

### Test-retest

In a sample of 21 CCT patients with mixed diagnoses who were tested during an intake evaluation and one week later before receiving cognitive therapy, the Pearson product-moment correlation between the test-retest scores was .69 ( $p < .001$ ). The test-retest reliability for another sample of 99 CCT patients who were tested at intake and six weeks later was .66 ( $p < .001$ ).

### Item Analysis

Table 1 presents the percentages of endorsement of hopelessness by sample group for individual items of the BHS. Since the BHS items are dichotomous and scored as 0 or 1, each item's mean multiplied by 100 yields the percentage of individuals choosing the alternative of hopelessness represented by that item. Percentages varied widely across clinical samples; for example, only 8% of the alcoholics reported hopelessness on item #1, whereas 68% of the recurrent-episode Major Depression patients did. The recurrent-episode Major Depression patients had the highest mean BHS score ( $M = 10.47$ ,  $SD = 5.70$ ), followed by the single-episode Major Depression ( $M = 10.10$ ) and Dysthymic ( $M = 9.03$ ) patients. The suicide ideators ( $M = 9.28$ ) and attempters ( $M = 8.86$ ) were next, and the alcoholics ( $M = 4.86$ ) and heroin addicts ( $M = 3.89$ ) had the lowest mean BHS scores.

The corrected, point-biserial item-total correlations also varied across the seven clinical samples (Table 1). All of the correlations were significant beyond the .01 level, one-tailed test, and the majority of correlations were greater than .50 for each sample.



## **Validity**

Six aspects of the validity of the BHS will be considered: (1) content, (2) concurrent, (3) discriminant, (4) construct, (5) predictive, and (6) factorial.

### **Content Validity**

The BHS was designed to follow closely Stotland's (1969) conception of hopelessness as a system of negative attitudes concerning the person's future. Most of the items in the scale were selected from a large pool of statements made by patients who were asked to describe their expectancies when they were de-pressed and not depressed. The procedures to assure the "face validity" of the BHS' content have already been presented in the Introduction section of this Manual.

### **Concurrent Validity**

Beck et al. (1974) examined the relationship between clinical ratings of hopelessness and BHS scores. The Pearson product-moment correlations of the BHS with clinical ratings of hopelessness were compared in two samples: (1) 23 outpatients in a general medical practice, and (2) 62 hospitalized patients who had made recent suicide attempts. The clinicians in each of the studies used an 8-point rating scale. The correlations with the clinical ratings of hopelessness were .74 ( $p < .001$ ) in the general practice sample and .62 ( $p < .005$ ) in the attempted suicide sample. The interrater reliability of two judges was .86 ( $p < .001$ ).

Table 2 presents correlations of the BHS with the Beck Depression Inventory (BDI) for the seven normative samples. The BHS was significantly related to the BDI beyond the .001 level, one-tailed test in all seven samples. The typical correlations reported in the psychiatric literature between the BHS and the BDI may be inflated in some instances because some studies have not reported subtracting the Pessimism rating from the BDI total score before correlating it with the BHS. In fact, Beck et al. (1974) used the correlation between the BDI Pessimism item and the BHS ( $r = .63$ ,  $p < .001$ ) as one of their indices of concurrent validity. The Pearson product-moment correlations between the BDI Pessimism item for patients with single-episode Major Depression Disorders, recurrent-episode Major Depression Disorders, and Dysthymic Disorders were .56, .56, and .64, respectively. All of the correlations were significant beyond the .0001 level, one-tailed test. The correlations of the total BDI scores minus the Pessimism item with the BHS scores were also all highly significant (see Table 2, page 14), with the highest being .74 for the alcoholic sample.

Table 2. Correlation Coefficients between the BHS and Sex, Age, BDI Total Score, and BDI Pessimism Item by Sample Group

<b>Sample</b>	<b>Sex</b>	<b>Age</b>	<b>BDI<sup>a</sup></b>	<b>BDI Pessimism Item</b>
<b>Suicide Ideators</b> ( <i>N</i> = 165)	.01	-.01	.61(.59)	.58
<b>Suicide Attempters</b> ( <i>N</i> = 437)	.04	-.01	.70(.68)	.66
<b>Alcoholics</b> ( <i>N</i> = 105)	.12	.01	.76(.74)	.74
<b>Heroin Addicts</b> ( <i>N</i> = 211)	.11	-.07	.46(.44)	.42
<b>Single-Episode Major Depression</b> ( <i>N</i> = 72)	-.02	.24*	.51(.49)	.56
<b>Recurrent-Episode Major Depression</b> ( <i>N</i> = 134)	.06	.11	.64(.62)	.56
<b>Dysthymics</b> ( <i>N</i> = 177)	-.01	-.10	.64(.62)	.64

\*Toe coefficients in parentheses represent correlations in which the Pessimism has been subtracted from the BDI total score.

### Discriminant Validity

The BHS was not designed to discriminate patients with different psychiatric diagnoses. However, Beck, Riskind, Brown, and Steer (in press) have been able to differentiate DSM-III Major Affective Disorders (Major Depression, Dysthymic, etc.) from Generalized Anxiety Disorder (GAD) using the BHS. The BHS scores of 199 outpatients diagnosed with Major Depressive Disorders ( $M = 11.3$ ,  $SD = 5.2$ ) were compared to those of 48 with Generalized Anxiety Disorders ( $M = 7.9$ ,  $SD = 4.9$ ) and 76 psychiatric patients with mixed nonaffective, nonanxiety disorders ( $M = 6.6$ ,  $SD = 5.0$ ). The Major Depressive patients had higher mean BHS scores than either the GAD or control patients.

Further data on the psychometric characteristics of the BHS have been provided by Durham (1982) for 99 forensic psychiatric patients, 118 general psychiatric patients, and 197 college students. The mean BHS score for the forensic psychiatric patients was 6.62 ( $SD = 4.88$ ); for the general psychiatric, 6.04 ( $SD = 4.67$ ); and for the college students, 2.32 ( $SD = 2.25$ ). The Kuder Richardson (KR-20) reliabilities were .83, .86, and .65 for the forensic psychiatric, general psychiatric, and college students, respectively.

The levels of hopelessness prevalent in a general adult sample were reported by Greene (1981) for 396 randomly selected Irish adults. The mean BHS score was 4.45 ( $SD = 3.09$ ). The BHS score was not significantly related to sex but was positively related to age. There was also a linear increase in BHS scores with respect to decreased socioeconomic status. Widowed, separated, and divorced respondents described themselves as significantly more pessimistic than married persons who, in turn, described themselves as more pessimistic than those who were never married. However, all of these differences were small and explained less than 12% of the variance in the relationship with any of the background characteristics. The mean BHS score of the normal adults was thus approximately one standard deviation lower than that reported by Beck, Kovacs, and Weissman (1975) for suicide attempters.

Topol and Reznikoff (1982) studied hopelessness in 30 hospitalized adolescent suicide attempters, 35 adolescent psychiatric inpatients, and 35 suburban high school students aged 13 to 19. The samples were matched with respect to race and socioeconomic levels. The BHS scores indicated that the suicide attempters described a greater degree of hopelessness than either the inpatients or the high school students.

Several studies have also attempted to assess the discriminant validity of the BHS in samples expected to differ in their degrees of hopelessness. For example, Greene, O'Mahony, and Rungasamy (1982) studied the levels of hopelessness in hospitalized, physically ill patients. They compared the mean BHS scores of 30 chronically ill ( $M = 4.2$ ,  $SD = 3.2$ ) and 30 acutely ill ( $M = 3.2$ ,  $SD = 2.1$ ) patients and found no significant mean differences. The mean level of hopelessness ( $M = 3.75$ ,  $SD = 2.7$ ) described by all 60 physically ill patients was lower than that described by Beck et al. (1975) for psychiatric inpatients ( $M = 9.0$ ,  $SD = 6.1$ ), but surprisingly it was not different from the mean BHS score for adults in general ( $M = 4.45$ ,  $SD = 3.1$ ) (Greene, 1981).

Rideout and Montemuro (1986) studied hope, morale, and adaptation in 23 patients with chronic heart failure. As expected, the mean BHS score of 7.04 ( $SD = 3.74$ ) was inversely related to morale and social functioning in these

chronic heart-failure patients. Their mean BHS score was significantly higher than that reported by Greene (1981) for a general adult normal population.

### **Modification for Age**

As previously mentioned, the BHS has been used to assess pessimism in clinical populations aged 13 to 80 years. Table 2 presents correlations between the Scale and age and sex for seven clinical samples. No significant relationship was found between BHS scores and sex. BHS scores were significantly related to age only in the single-episode Major Depression group. This correlation, however, was rather small ( $r = .24$ ), and less than 6% of the variability in BHS scores can be attributed to age. Also Greene (1981) found no significant correlation between the BHS and age. Therefore, age and sex adjustments to BHS scores are not necessary.

### **Construct Validity**

As previously mentioned, the BHS was developed for studying hopelessness in psychiatric patients, especially those considered to be at risk for committing suicide. Therefore, the majority of the studies conducted with the BHS have been performed with patients displaying a variety of suicidal behaviors. Beginning with data from the *Generalized Expectancy Scale* (GES) (Minkoff et al., 1973), hopelessness has been found to be positively correlated with depression. For example, Minkoff et al. (1973) reported that the Pearson product-moment correlation between the BDI (Beck, Ward, Mendelson, Mock, & Erbaugh (1961) and the GES was .68 ( $p < .001$ ) for 68 suicide attempters. Using partial correlational analyses to study the relationships between depression, hopelessness, and suicidal intent, they reported that the relationship between hopelessness and suicidal intent ( $r = .47$ ) was significantly higher than that between depression and suicidal intent ( $r = .26$ ). Thus, a series of research studies emerged in the psychiatric literature indicating that the BHS was a better predictor of suicidal intent than was depression.

Using partial correlational analyses Kovacs, Beck, and Weissman (1975) found that when hopelessness was controlled for, depression was not significantly related to suicidal intention in hospitalized depressed patients ( $r_p = .06$ ). In contrast, when depression was controlled for, hopelessness still remained positively correlated with suicidal intent ( $r_p = .24, p < .001$ ). These results were later replicated by Wetzel (1976) with 48 suicide attempters, 56 suicide ideators, and 50 psychiatric controls using the Zung Depression Inventory (Zung, 1965) as the measure of depression. For both the ideators and attempters, hopelessness was a better predictor of suicidal intent than was depression. Furthermore,

the ideators had higher mean levels of hopelessness than the attempters, and both of these groups had higher mean levels of hopelessness than the psychiatric controls.

In studying attempted suicides, Dyer and Kreitman (1984) reported that for 120 self-poisoners in Scotland, whose mean BHS score was 12.1 (SD = 5.4), the BDI scores were not significantly correlated with suicidal intention when hopelessness (as measured by the BHS) was controlled for, but hopelessness still remained significantly correlated ( $r = .32$ ,  $p < .01$ ) with suicidal intention when BDI scores were controlled for. Hopelessness, as measured by the BHS, was also described by Williams (1986) as related to different reasons given by patients for drug overdose. Persons with low levels of hopelessness gave interpersonal reasons for their suicide attempts, whereas persons with high levels of hopelessness described wishing to escape their problems.

Wetzel, Margulies, Davies, and Karam (1980) have concluded that the suicide literature indicates that the BHS has proven to be a more robust predictor of suicidal behavior than has depression as measured by the BDI. The BHS has also been used to estimate the relationship between suicidal ideation and intention in a variety of clinical populations considered at risk for suicide, such as substance abusers and the chronically ill. For example, in studying the relationships among hopelessness, depression, previous suicide attempts, and suicidal ideation, Beck, Steer, and McElroy (1982) used a multiple regression analysis and found that the BHS contributed 42% to the explanation of suicidal intention as measured by the *Suicide Intent Scale* (SIS) (Beck, Schuyler, & Herman, 1974); whereas the BDI and the number of previous attempts explained less than 1%. Similarly, Beck, Weissman, and Kovacs (1976) compared 126 alcohol attempters and 252 nonalcohol attempters in their longitudinal study of suicidal behavior and found that the BHS was a better predictor of suicidal intention than was the BDI. Weissman, Beck, and Kovacs (1979) compared 384 nondrug-abusing suicide attempters with 86 drug-dependent suicide attempters and found similar results. Once again, controlling for the BDI, the relationship between hopelessness and suicidal intention was significant in drug dependent and nondrug-dependent groups. However, when the BHS was controlled for, the relationship between the BDI and the SIS was not significant in either the drug- or nondrug-dependent suicide attempters.

Expected reductions in BHS scores attributable to psychotherapeutic interventions have also been found. Blackburn and Bishop (1983) reported, and Rush, Beck, Kovacs, Weissenberger, and Hollon (1982) found that after 11 weeks of treatment, cognitive therapy aimed at reducing hopelessness yielded greater reductions in hopelessness than did imipramine for 35 depressed patients. These results support the efficacy of cognitive therapy in reducing hopelessness.

## Predictive Validity

The predictive value of the BHS for identifying eventual suicides was studied by Beck, Steer, Kovacs, and Garrison (1985). In a 5- to 10-year prospective follow-up study of 165 patients hospitalized with suicide ideation, the BHS was found to be a powerful indicator of eventual suicide. Of the 11 patients who eventually committed suicide, 10 (90.9%) had BHS scores of 9 or higher. Only one patient who eventually committed suicide previously had received a BHS score lower than 9; the false-negative rate was, therefore, 9.1%. The mean BHS score was significantly higher in the suicide group ( $M = 13.27$ ,  $SD = 4.43$ ) than in the nonsuicide group ( $M = 8.94$ ,  $SD = 6.05$ ;  $t(163) = 2.33$ ,  $p < .05$ ).

As previously mentioned, Beck, Brown, Berchick, and Steer (1987) described a study in which 1,969 outpatients evaluated at the CCT between 1978 and 1984 were administered the BHS. Of the 16 who eventually committed suicide, 15 (93.8%) had BHS scores of 9 or above. The false-negative rate was 6.2%. Of the 1,953 patients who did not commit suicide, 1,152 (58.5%) had BHS scores of 9 or above. The mean BHS scores for the outpatient suicide and nonsuicide groups were 15.13 ( $SD = 4.56$ ) and 9.99 ( $SD = 5.43$ ), respectively. The mean BHS score of the suicide group was significantly higher than the mean BHS score of the nonsuicide group ( $p < .001$ ). This study thus provided a replication with outpatients of Beck et al.'s (1985) findings with inpatients.

## Factorial Validity

To determine whether or not the BHS represents a homogeneous set of items reflecting hopelessness, as opposed to complex subsets of items representing distinct scales themselves, several authors have conducted factor analyses of the BHS with different clinical populations. A principal components analysis of the BHS responses for 294 suicide attempters revealed three components: (1) feelings about the future, (2) loss of motivation, and (3) future expectations (Beck et al., 1974).

The BHS appears to have different factor structures depending upon the types of clinical populations that are studied. For example, Nekanda-Trepka, Bishop, and Blackburn (1983) conducted a principal components analysis with 83 patients with primary major depressions whose mean BHS score was 13.05 ( $SD = 5.17$ ). Five components representing (1) motivation and outcome, (2) confidence in the future, (3) future accomplishments, (4) trust in the future, and (5) time perspective emerged. Finally, Beck, Steer, and Shaw (1984) compared the principal components structures of alcoholic and heroin addicted women and found that the five most discriminating items were: (1) life in IO years, (2) accomplishments, (3) success, (4) not being able to get what I want, and (5)

anticipation of good times. The alcoholic women believed that they would be happier in the future and accomplish more than did the women who were addicted to heroin.

## **Social Desirability**

The issue of social desirability and its relationship to the BHS has generated considerable debate about the interpretation of the association between the BHS and suicide ideation and, consequently, about the construct validity of the BHS. Fogg and Gayton (1976) found that social desirability as measured by the *Edwards Social Desirability Scale* (ESDS) (Edwards, 1970) was inversely related to the BHS ( $r = -.64$ ), suggesting that hopelessness may be measuring a tendency to describe oneself in a socially undesirable way. Their paper initiated a series of articles weighing the impact of social desirability upon hopelessness and its linkage with suicidal ideation.

Linehan and Nielsen (1981) studied 196 male and female shoppers at a mall using the ESDS, the BHS, the BDI, and self-reported estimates of suicidal ideation and behavior. The relationship between the BHS and the ESDS was  $-.67$  ( $p < .001$ ). Controlling for social desirability, the relationship between the BHS and current suicidal ideation and past suicidal behavior dropped from  $.16$  to  $.12$ , respectively.

In contrast, Petrie and Chamberlain (1983) used the *Crowne-Marlowe Scale of Social Desirability* (CM) (Crowne & Marlowe, 1960) with 54 suicide attempters and found that the relationship between the CM and the BHS was  $-.30$ . The magnitude of this relationship suggested that the CM did not alter the relationship between the BHS and suicidal behavior (i.e., the BHS remained significantly related to suicidal behavior after the influence of social desirability, as measured by the CM, was partialled out).

Nevid (1983) challenged the conclusions drawn by Linehan and Nielsen (1981) and stated that self reports of hopelessness were not confounded with social desirability but instead reflected aspects of psychiatric dysfunctioning, such as dichotomous thinking. Linehan and Nielsen (1983) rebutted Nevid's (1983) article and contended that social desirability was an important issue and that patients who are trying to manage the impressions they are giving are not prepared to give a lot of information about their past or current suicidal ideation. Their attempts at impression management may thus be mistaken for the types of cognitive distortions indicative of depression. Mendonca, Holden, Mazmanian, and Dolan (1983) used the Desirability and Infrequency Scales of the *Jackson Personality Research Form* (Jackson, 1974) to study the differential reliability of the BHS with 41 suicide ideators, 10 attempters, and 27 controls.

The relationship between the Desirability Scale and the BHS was  $-.71$ , whereas the relationship between the Infrequency Scale and the BHS was  $.23$ .

Holden and Medonca (1984) called for the empirical disentanglement of hopelessness from the social desirability issue and indicated that the conflicting results may reflect not only upon the different types of social desirability instruments being used but also upon different types of samples being employed. Nevertheless, Strosahl, Linehan, and Chiles (1984) persisted in their claim that the issue of social desirability was important in establishing the linkage between suicidal behavior and hopelessness and indicated that the BHS yielded a high level of false negatives in both general populations and psychiatric samples when social desirability was not employed along with it. Strosahl et al. (1984) recommended that a measure of social desirability be used in addition to the BHS to cut down on the number of false positives and negatives to increase the utility of predicting suicidal ideation in target populations.

Beck, Brown, Berchick, and Steer (1984) reported simultaneous cut-off scores with the BDI and the BHS to reduce the number of false positives and negatives in predicting eventual suicide by psychiatric outpatients. Studying 1,969 patients evaluated at CCT between 1978 and 1984, they found that 16 (0.8%) committed suicide. A BHS cut-off score of 9 or above identified 15 (93.8%) of the 16 suicides, and a BDI cut-off score of 23 or above identified 13 (81.2%) of the 16 suicides. The specificity rates for the BHS and BDI were 62.3% and 41.0%, respectively, using the aforementioned optimal cut-off scores. Specificity was operationally defined as the percentage with which the BDI or BHS was able to correctly predict how many of the 16 suicide attempters committed suicide; and sensitivity was operationally defined as the percentage with which the BDI or BHS was able to correctly identify how many of the 1,953 non-suicide attempters would be nonsuicides. The simultaneous use of the BHS and BDI cut-off limits yielded a sensitivity rate of 81.2% and a specificity rate of 68.2%.

Finally, Cole (1988) investigated the relationship among hopelessness, depression, social desirability, and suicide ideation in 130 nontreatment-seeking and 125 treatment-seeking college undergraduates. He found that hopelessness was related to suicide ideation in the treatment-seeking students even after social desirability and depression were controlled for, but it was not related to suicidal ideation in the nontreatment-seeking students after social desirability was controlled for. Multiple instruments for assessing depression, hopelessness, and social desirability were employed. The choice of social desirability instrument was important; the ESDS was overly sensitive to depression, whereas the CM was not. His results, therefore, resolved some of the contradictions about the relationship between hopelessness and social desirability. Social desirability did



account for the relationship between the BHS and suicide ideation in the nontreatment-seeking sample as Linehan and Neilsen (1981) had described, but the CM did not account for the relationship between the BHS and parasuicide in the treatment-seeking sample.

Nevertheless, the CM and ESDS themselves contain a number of items relevant to psychopathology and indeed have items which are similar to those found in the BHS. Cole (1988) conjectured that the low correlation between hopelessness and suicidal ideation and behavior in the nontreatment seeking sample might be attributable to the restricted range of psychopathology described by a nonclinical population. His conjecture is perhaps the most perceptive in the BHS-social desirability debate in that the BHS has repeatedly been found to be a better predictor of suicidal intent than depression in clinical populations, regardless of social desirability (Beck, 1986). Therefore, because clinicians would rather error in the direction of overestimating suicidal ideation in their patients rather than underestimating it, the use of a social desirability instrument along with the BHS to decrease the number of false positives is not recommended.

# Clinical Uses of the *Beck Hopelessness Scale*

## As a Predictor of Suicide During Therapy

P.B. was a 49 year old, unemployed, married father of three children. He had attempted suicide several times. At the age of 34, he had experienced his first major depressive episode followed by numerous repeated episodes associated with job difficulties. Specifically, he had 25 different jobs, each job change being associated with a relapse. In the past he had twice attempted to electrocute himself and had taken an overdose of Dalmane.

Five months prior to his referral to the Center for Cognitive Therapy, he was fired from his position as a salesman. This event led to an exacerbation of his depressive symptoms. He was then hospitalized for two and one-half months.

At the time of his evaluation at the Center for Cognitive Therapy, his self-report scores as well as interview report reflected severe depression but *no suicidal ideation*. His BDI score, for example, was 45. He endorsed Item 9 as "I don't have thoughts of killing myself." Similarly, the *Scale for Suicide Ideation* did not indicate current suicidal thoughts or plans. However, his BHS score was 20.

He came in for three consecutive sessions, canceled the fourth, and did not show up for the next scheduled appointment. Scores on the BDI during the three sessions he had kept dropped from 45 at admission to 35, 37, and 37, respectively. During the sessions the patient denied verbally and on self-report forms any suicidal thoughts or plans. However, his BHS remained high (again a score of 20).

When the patient canceled his appointment, the therapist asked for the reason, and the patient replied that he had a job interview. The therapist probed for suicidal ideation, and the patient denied having any suicidal wishes or plans. The therapist then agreed not to reschedule his appointment for that week but to see the patient the following week since "he has been showing signs of reduction from depression" (10 point drop on the BDI). The patient, however, did not show up for the next appointment. When the therapist called his home, he learned the patient had committed suicide three days prior. The wife reported that it was a shock as he had not shown any signs of suicidal wishes as he had in the past.

Conclusion: In the presence of a high BHS and dropping BDI, the therapist should have been alert to the possibility of a suicide attempt when the patient canceled his appointment. Nevertheless, the BHS accurately reflected suicidal

risk whereas the patient's self-report of suicidal ideation or the suicide item on the BDI did not.

Another important therapeutic point is that the therapist did not directly address the patient's hopelessness in therapy but concentrated instead on issues regarding employment. Past research with cognitive therapy has shown that the cognitive distortions underlying hopelessness are generally very amenable to change if they are elicited and challenged. Thus, the BHS is a valuable tool in suggesting a crucial area for intervention.

### **As a Lead to Assessing Suicidal Ideation**

J.D. is a 34 year old, single male employed as an attorney in private practice. Although he presented a major depressive episode (BDI = 31) and denied suicidal ideation, he showed a severe level of hopelessness (BHS = 20). Upon probing behind the BHS score, J.D. acknowledged that often when he was feeling extremely depressed, he felt overwhelmed by problems for which he could see no solutions. He then admitted that he imagined himself "blowing his brains out" with the revolver given to him by his father. Once the reasons for his suicidal fantasies and his hopelessness were addressed, the patient became less pessimistic. As he realized that he did have options other than suicide, his BHS scores began to drop. By the sixth week of treatment, they were within a normal range (5), and he was no longer depressed.

Conclusion: With J.D. and many other patients who give negative reports of suicide ideation, clinicians are apt to move on to the usual direct questions; however, when the BHS score is high, it is important to inquire about the reasons for specific hopeless responses to the BHS items. Exploration of these responses may lead to acknowledgement of suicidal wishes.

### **As a Clue to the Source and Resolution of a Clinical Impasse**

L.W. is a 44 year old, married woman and mother of two teenage daughters, aged 19 and 15, respectively. Her husband of twenty years is a successful business consultant.

L.W. came to the Center with symptoms of a primary Major Depressive Episode superimposed on Dysthymia and a secondary Panic Disorder with Avoidance. At the time of her initial diagnosis and treatment evaluation, her BDI was 24, indicating moderate depression, and her *Beck Anxiety Inventory* score was 36, indicating moderate to severe anxiety. The total score on the BHS was 20. She denied suicidal ideation, and this verbal self-report was consistent

with her endorsement of the BDI item, "I do not have any thoughts of killing myself." When asked directly about suicide, she responded with "for religious reasons I would not even consider that as an option."

At the beginning of treatment, she reported that the major depressive episode as well as the panic attacks began shortly after her eldest daughter left for college. L.W. was close to this daughter, and they would do many things together. L.W. reported that she "always" had a strained relationship with the youngest child and that her husband was "never home" as he was "always" working. Therefore, L.W. found herself home alone quite often with nothing to do but lie in bed for days.

The treatment plan was to focus on the panic attacks with avoidance (since the prognosis was good, and effective treatment would allow her to be more mobile) and to break up her inactivity. As progress came, more efforts would be made to focus on restructuring the negative automatic thoughts associated with her depression.

At first it appeared that all was going well; she responded well to the cognitive therapy treatment package for panic. However, she did not experience any relief in her depression nor experience much pleasure or satisfaction from her activities. She identified many automatic thoughts relating to themes of worthlessness and anger at her husband and youngest daughter. L.W. was able to generate rational responses but did not have much belief in them.

As a result of the lack of progress in the treatment of depression, the therapist reviewed the self-report measures (BDI and BHS) with the patient. When discussing specific items on the BHS with the patient, the therapist learned of the patient's deep belief in the hopelessness of her marriage and a conviction she could not change: she believed she was a bad person. She felt trapped in her marriage due to her religious beliefs; she couldn't leave her husband or even escape via suicide. In addition, she was "so terrible" that the whole situation was hopeless. She would go through the motions but could not really contemplate the possibility of change. Once these negative beliefs were identified and discussed, the patient progressed rapidly. Her BHS dropped gradually from 20 to 18 to 16 and after four more weeks to 7.

Conclusion: The BHS is a valuable tool for indicating that the patient is still pessimistic (and possibly suicidal) even though significant improvement in symptoms has occurred. By discussing the specifically endorsed items on the BHS with the patient, the therapist can then pinpoint some of the particular situational and psychological factors contributing to a therapeutic impasse.

## **As a Technique to Facilitate Movement in Therapy**

H.N. is a 20 year old, single, female college student. She presented a history of chronic depression, which was exacerbated by her observation that her classmates had career plans and relationships, and she never did. As H.N. was reticent and not forthcoming with information during the clinical interview, family members were contacted to elicit background data. Her mother reported that H.N. had been shy, withdrawn, and a loner since her father died when she was eight. At the time of the initial evaluation, H.N.'s self-report scores were as follows: *Beck Depression Inventory* 38, *Beck Anxiety Inventory* 27, *Scale for Suicide Ideation* 5, and *Beck Hopelessness Scale* 19.

The patient's reticence made the therapy sessions difficult at times. With great reluctance she would make a statement such as, "Other students fit in - I don't." When asked to reflect on and examine that statement, she would say, "I didn't mean to say that" or "I'm not sure what I mean" and then become non-communicative. After several unsuccessful attempts to examine her automatic thoughts, we turned to the items on her BHS to generate issues to address.

The therapist concentrated on the following three items: (Z) "I might as well give up because there is nothing I can do about making things better for myself," (I) "I just can't get the breaks, and there's no reason I will in the future," and (P) "I never get what I want so it's foolish to want anything." At first the therapist, using the information primarily from family members, listed evidence to the contrary for each of these items and then discussed her dichotomous thinking. After this session and a moderate reduction in hopelessness (to 12), the patient began to be more collaborative in therapy.

Conclusion: Focusing on specific relevant items on the BHS can help to break up a pervasive hopelessness and foster collaboration.

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